STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	C 10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, the facility failed to assess 1 of 1 sampled resident (Resident # 17) that was observed with medication at the bedside for self administration of medication. Findings included: Resident # 17 was readmitted on 2/28/14 with diagnoses that included hypertension, diabetes and hypothyroidism. Review of the October 2014 physician's orders did not indicate an order for Natural Tears or orders for Resident # 17 to keep medications at the bedside or self administer any medications. The quarterly Minimum Data Set (MDS), dated 10/13/14, indicated the resident was cognitively intact. There were no behaviors or rejection of care documented. The care plan, most recently reviewed on 10/15/14, revealed the resident had not been care planned for self administration of medication. An observation was made on 10/20/14 at 12:54 PM. Resident # 17 had Natural Tears (a	F 176	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F 176 RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE Criteria #1 Resident # 17 was assessed for her ability to self-administer medications safely and was deemed competent. An order was obtained for resident # 17 to self administer and keep Artificial Tears at bedside on 10/22/14. The Minimum Data Set Coordinator entered a care plan to reflect the self-administration of Artificial Tears. All of the resident□s contacts were made aware not to bring outside medications to the resident and that all medications will be provided by the facility following and according to Physician orders. 11/10/14	11/13/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/13/2014

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F 176	Continued From page 1 lubricating eye drop) on her over bed table. The table was within easy reach of the resident and set along side her water pitcher and other personal items. At 3:02 PM, during a resident interview, the eye drops remained on the over bed table. An observation was made on 10/22/14 at 10:14 AM. Natural Tears were observed at the bedside, located on the over bed table that had been positioned so Resident # 17 could reach the items on the table. Nursing Assistant # 1 was in the room at this time. Nursing Assistant # 1 (NA) was interviewed on 10/22/14 at 10:42 AM. The NA stated if she saw medication at a resident's bedside she would report it to the nurse. She added she had not seen medication at any resident ' s bedside recently. An interview was held with Nurse # 1 on 10/22/14 at 10:51 AM. Nurse # 1 is Resident # 17's primary nurse on the day shift. She stated prior to self administration an order was needed to self administer. The nurse stated Resident # 17 had not been assessed to self administer and did not have an order to keep any medication at bedside. She added the resident did not have an order for Natural Tears. Nurse # 1 stated she was unaware the resident had medication at her bedside. An interview was held with Resident # 17 on 10/22/14 at 11:30 AM. The Natural Tears eye drops were observed setting on the over bed table. Resident # 17 stated the eye drops were some she had at home. She added she had been told she could not self administer	F 176	Criteria #2 All residents have the potential to be affected by this alleged deficient practice, therefore, an audit was conducted of all resident rooms to identify any resident with medications in their room. Medications were removed unless the resident has been assessed and remain appropriate for self-administering of medications. 11/13/14 Criteria #3 All Nurses and Med Aides will be in-serviced by the Staff Development Coordinator regarding the Self Administration of Medication Policy to include: Residents that request approval to self-administer meds will be assessed by the Interdisciplinary Team to determine if competent and physically able to do so, MD order must be obtained for self-administration, bedside storage of medication, documentation guidelines and the reassessment every three months by the Interdisciplinary Team to determine continued competency. CNAs will be in-serviced regarding the reporting of medications observed at the bedside to the nurse. All staff that has not been in-serviced by the target date will be removed from the schedule until they have been re-educated. Social Services Director sent out letters to all resident□s Responsible Parties to reiterate not to bring outside medications to the facility and give to the residents. 11/12/14	

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F 176	Continued From page 2 medications, but stated she did not think that rule covered eye drops. The resident added when she finished the eye drops she brought from home, she would get the facility to get her more. The resident stated she had spoken about the eye drops to her evening nurse (Nurse # 2) and he had told her it was ok for her to have those drops. An interview was held with the Staff Development Coordinator (SDC) on 10/22/14 at 11:47 AM. She stated before a resident can self administer medications, a doctor's order for the medication must be obtained. The SDC identified one resident in the facility that self administered medication. The identified resident was not Resident # 17. Nurse # 2, the resident 's evening nurse, was interviewed on 10/22/14 at 4:24 PM. Nurse # 2 stated there was no resident on the hall that self administered medication. He added he was unaware of any resident that kept medication at bedside. The nurse stated he was unaware Resident # 17 had Natural Tears at bedside and denied telling her it was ok to keep the medication at her bedside. The Nurse Team Leader was interviewed on 10/23/14 at 8:51 AM. Prior to keeping medications at bedside, an order had to be obtained. The team leader added the ability to self administer and a return demonstration of correct medication application had to be completed.	F 176	Criteria # 4 Observation for medications in resident rooms including the over bed table, bedside table, and dresser will be added to the Quality Rounds conducted by the Administrative Staff. Rounds are to be done weekly by Administrator, Activity Director, Medical Records Director, Social Services Director and the Admission Coordinator. Director of Nursing will report any significant findings from the follow-up to the Quality Assurance Committee for 3 months or as deemed necessary. 11/13/14	
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS	F 257		11/13/14

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F 257	Continued From page 3 The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review the facility failed to maintain comfortable temperatures in 1 of 5 hallways (hallway in the locked unit) and 1 of 2 common areas (lobby). Findings included: An undated Environmental Safety Policy indicated the facility was maintained at a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit. Review of facility grievances, revealed a grievance placed by Resident # 3 on 6/03/14. The resident alleged the temperature in the dining room was too cold at breakfast. On the grievance form, under Action, was documented the temperature would be adjusted prior to breakfast to make it warmer in the morning and then adjusted later in the day to make the temperature comfortable for the rest of the day. The grievance was designated as "resolved' on 6/12/14 and signed by the Administrator. During an interview with Resident # 3 on 10/21/14 at 9:28 AM, she stated the facility was cold. She identified the hallways and common areas as the coolest areas. She added she had previously mentioned this problem to facility staff.	F 257	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. Criteria #1 The thermostat was adjusted in the two affected areas to bring the temperature within acceptable ranges (71-81 degrees)as read by the thermometer on the thermostats. 10/22/14 Criteria #2 All residents have the potential to be affected by this alleged deficient practice, therefore, the thermostats in the area in question were inspected and calibrated by the facility□s HVAC service provider. 11/5/14 Criteria #3 Maintenance Director was in-serviced by Executive Director as to policy on what temperature range	

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F 257	Continued From page 4 Observations were made on 10/22/14 beginning at 9:44 AM with the assistance of the Maintenance Director. The temperature in the dining area was 72 degrees with the thermostat set at 73 degrees. The Maintenance Director (MD) stated he and the nurses were the ones with access to the thermostats. He added he had received no complaints about facility temperatures. The MD added he occasionally looked at the thermostats, but not on a daily basis. He denied he had been coming into the dining room on a daily basis and adjusting the thermostat and then readjusting later in the day. The MD added there had been problems with several of the air conditioning (AC) units this past summer, but parts were replaced and repaired as needed. Temperatures were not taken while the AC was out, so therefore, he had no idea how hot the building had gotten. Fans were located in halls and resident rooms as needed. During this time, temperatures were taken throughout the building. The thermostat in the lobby was set on 70 degrees with an actual temperature reading of 68 degrees. The MD acknowledged the thermostats were set on the AC and not heat. He added he did not think the thermostat was accurate, but had not called anyone to check for accuracy. He added it did not seem that cold to him. The thermostat within the locked unit was set on 73 degrees and read an actual temperature of 67 degrees. Residents were seen in the hallway with sweaters and long sleeves. The MD stated he thought the temperature of the facility should be maintained between 71 and 79 degrees. Since there were 2 thermostats that were not reading 71 degrees, he would get the company to come calibrate the thermostats. An interview was held with the Administrator on	F 257	(71-81 degrees) the facility should be maintained at. 10/23/14 Criteria #4 Executive Director or Maintenance Director will check thermostats daily x3 weeks, weekly x2 months to ensure comfortable temps (71-81 degrees). Log to be kept in Administrator□s Office. Results will be reported to QAA committee monthly x3 months by Executive Director. 11/3/14	

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F 257	Continued From page 5 10/22/14 at 2:07 PM. He stated over the summer there were a couple of issues with the AC units. He added there had been a resident that complained of the dining area being too cold. The issue was resolved by turning up the heat in the morning and then readjusting as the temperature in the facility warmed. By early July, the temperature was comfortable for the resident so therefore, the thermostat adjustments were discontinued. The Administrator added now that the weather was getting cooler, facility temperatures would be re-evaluated. The Administrator stated he was unsure how often the facility temperatures were checked, but thought it was only during complaints of when it was too hot or too cold. The Administrator stated when low temperatures were found during the morning, the MD should have flipped the switch to heat in order to bring the facility temperature up to the regulatory range. An interview with the Maintenance Director, at 2:20 PM, revealed he had adjusted the temperature up that morning after realizing the facility was cool, but did not turn the heat on. He had not realized that without putting the thermostat to heat, that increasing the temperature on the thermostat meant the AC would not come on until the higher temperature was reached and would not warm the common areas of the building. The MD stated he had not called the company to come check the accuracy of the thermostat. At this time the thermostat in the locked unit read an actual temperature of 68 degrees. The actual temperature reading in the common area of the lobby was 68 degrees.	F 257		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		11/13/14

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F 279	Continued From page 6 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop an interdisciplinary care plan for an indwelling urinary catheter for 1 of 3 residents (Resident # 17) that was reviewed. Findings included: Resident # 17 was readmitted on 2/28/14 with diagnoses that included hypertension, diabetes and hypothyroidism. Review of a nurse's note, dated 8/20/14 at 10:10 PM, indicated an order was received to place an indwelling urinary catheter for Resident # 17 at	F 279	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F 279 DEVELOP COMPREHENSIVE CARE PLANS Criteria #1 Resident # 17 had a care plan Implemented by the Minimum Data Set	

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F 279	Continued From page 7 the resident's request. The quarterly Minimum Data Set (MDS), dated 10/13/14, indicated Resident # 17 was cognitively intact. An indwelling urinary catheter was identified. The care plan, last reviewed on 10/15/14, did not include identification of the indwelling urinary catheter, measurable goals or approaches to minimize any risks that could be associated with the catheter. The MDS nurse was interviewed on 10/22/14 at 5:00 PM. She stated the last quarterly review for Resident # 17 occurred on 10/15/14. The MDS nurse stated she knew the resident had an indwelling urinary catheter and knew she was supposed to have care planned the catheter. The MDS nurse reviewed the resident's care plan and stated a care plan for a catheter was not included; adding it was an oversight.	F 279	Coordinator, to reflect the Indwelling urinary catheter. 10/22/14 Criteria #2 All residents with an indwelling urinary catheter has the potential to be affected by this alleged deficient practice, therefore, an audit of current residents with indwelling catheters was conducted to ensure that devices were included on the resident□s most recent comprehensive assessment and that it was reflected in the resident□s individualized care plan. 11/07/14 Criteria #3 In-service was provided by Director of Reimbursement/Minimum Data Set to the Minimum Data Set Coordinator regarding the requirement that the facility must develop a comprehensive care plan for each resident based on the care needs identified in the Comprehensive Assessment. 11/10/14 Criteria #4 The Corporate Consultant, Director of Nursing, Minimum Data Set Coordinator and/or ADON will complete an audit of all new admissions and readmission to ensure that the resident□s care needs are reflected in the plan of care to include: appropriate problems, goals and interventions as indentified in the most recent Comprehensive Assessment weekly x 4 weeks and then monthly x 2 months. The Director of Nursing will incorporate POC into the	

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F 279	Continued From page 8	F 279	facility□s monthly QAA meeting to evaluate effectiveness and compliance. 11/10/14	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of records, the facility failed to provide indwelling catheter care per facility policy for 1 of 2 residents (Resident # 17) whose catheter care was observed. Findings included: The facility identified the Lippincott Manual of Nursing Practice, 9th edition as their source for indwelling catheter care procedure. In Chapter 21, Page 785, the policy indicated the catheter should be cleaned around the area where it enters the urethral meatus with soap and water during the daily bath to remove debris. Resident # 17 was readmitted on 2/28/14 with	F 315	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER Criteria #1 NA #1 was re-educated and retrained regarding indwelling catheter care by the Staff Development Coordinator through 1 on 1 training. Proper return demonstration was	11/13/14

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F 315	Continued From page 9 diagnoses that included hypertension, diabetes and hypothyroidism. Review of nurse's notes and a physician's order, dated 8/20/14, indicated an indwelling urinary catheter was placed per the resident's request. Review of the October 2014 orders indicated catheter care was ordered for completion on every shift. The quarterly MDS, dated 10/13/14, indicated the resident was cognitively intact and had no behaviors or rejection of care. The MDS did identify the presence of an indwelling urinary catheter and identified the resident as requiring extensive assistance for personal hygiene. The care plan, with a review date of 10/15/14, did not address the indwelling urinary catheter, a measurable goal or interventions to minimize the risks associated with an indwelling urinary catheter. On 10/22/14 at 10:14 AM, Nursing Assistant (NA) # 1 was observed providing morning care, which included indwelling catheter care. The resident was lying on her right side. After completing bathing the resident's upper body, the NA changed the water and retrieved a clean washcloth. The NA then washed the resident's perineal area with a back and forth motion. The NA did not fold the washcloth and use a clean section for each swipe of the catheter and the perineal area. The resident's labia were not separated and the point at which the catheter entered the resident's body was not cleansed. The resident was not laid on her back in order to provide better access to the catheter.	F 315	provided by NA #1 to the Staff Development Coordinator. Proper indwelling catheter care was provided to resident # 17. 10/23/14 Criteria #2 All residents with an Indwelling urinary catheter has the potential to be affected by this alleged deficient practice, therefore, an audit was conducted to identify all residents with an indwelling urinary catheter. 11/04/14 Criteria #3 All Nursing staff was re-educated by the Staff Development Coordinator on the facility policy and appropriate procedure for providing Indwelling catheter care to include: hand washing, donning gloves, cleaning of the area of insertion away from the body, avoiding the use of powders and sprays, avoiding tension on the catheter during cleaning, doffing gloves and hand washing. All staff that has not been in-serviced by the target date will be removed from the schedule until they have been re-educated. Random pericare and catheter care audits were conducted by Staff Development Coordinator on varying shifts and units to ensure that proper pericare and indwelling catheter care procedure is carried out by staff. 11/12/14	

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F 315	Continued From page 10 An interview was held with NA # 1 on 12/22/14 at 10:42 AM. The NA stated she had been taught to complete catheter care using alcohol wipes. She stated she was taught to wipe the perineal area from front to back and the catheter tubing from where the tubing entered the body out. She acknowledged that she did not wash from front to back, but instead used a back and forth motion. The NA added she could not separate the resident's labia and clean the catheter insertion site with the resident lying on her right side. She stated she was nervous. Nurse # 1 was interviewed on 10/22/14 at 10:51 AM. During catheter care, staff were trained to clean from the urinary meatus out using a different section of the cloth with each swipe. With females, staff are taught to always clean from front to back. Without spreading the labia you cannot clean the meatus. An interview was held with the staff development coordinator (SDC) on 10/22/14 at 11:47 AM. She stated staff were taught to wash females from front to back. Catheters should be washed from the urinary meatus outward. She added staff were not taught to use back to front motions or alcohol wipes to complete catheter care. The nurse Team Leader (TL) was interviewed on 10/23/14 at 8:51 AM. The TL stated in order to perform indwelling catheter care, the woman's labia should be separated and the catheter tubing cleansed from the urinary meatus outward.	F 315	Criteria #4 Director of Nursing, Assistant Director of Nursing, Staff Develop Coordinator and RN Supervisors will continue random audits weekly of indwelling urinary catheter care on varying shifts and units to ensure proper catheter care is being provided to all identified residents. A minimum of 3 audits will be conducted 1 x week x 4 weeks, a minimum of 3 audits every 2 weeks x 1 month and a minimum of 3 audits monthly x 1 month. Results will be recorded on the Pericare/Indwelling Catheter Care Audit tool and will be kept in the Director of Nursings office. The Director of Nursing will incorporate the POC into the facility□s monthly Quality Assurance and Assessment meeting. The Director of Nursing will report any occurrences of inappropriate pericare or catheter care.from the follow-up to the Quality Assurance Committee for 3 months or as deemed necessary. 11/12/14	
F 371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		11/13/14

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F 371	Continued From page 11 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure one of one convection oven was clean and free of burnt material in the bottom of the oven. On 10/22/14 at 4:30pm during a tour of the kitchen an observation of the convection oven revealed an area 2 inches deep along interior front edge of the oven was covered with a layer of burnt food which extended the width of the oven. During an interview with the Assistant Dietary Manager on 10/22/14 at 4:45pm she stated she was working as the cook. She stated the oven was last cleaned the first of the month and had not been cleaned more recently due to not having enough staff. She stated she was working as the fill in cook and had not cleaned the oven when it became dirty. The corporate support dietitian was present during the tour and interview on 10/22/14 at 4:40pm. She stated she felt the oven should have been cleaned.	F 371	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. Criteria #1 The oven was deep cleaned on 10/22/14 Criteria #2 All residents have the potential to be affected by this alleged deficient practice, therefore, all dietary staff were in-serviced on the cleaning list and daily/weekly cleaning of the oven. The in-service was conducted by the Dietary Manager. 10/23/14 Criteria #3 The oven will be monitored daily by the dietary manager, dietary assistant and or cook on duty for the next month. The oven will be monitored weekly for 4 months by the dietary manager,	

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	345510	A. BUILDING _____ B. WING _____	C 10/23/2014

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F 371	Continued From page 12	F 371	dietary assistant and or cook on duty. Results will logged and kept in the Dietary Manager's office. Results will be given by the Dietary Manager at QAA meetings monthly for 3 months.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		11/13/14

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F 441	Continued From page 13 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of records, the facility failed to follow proper handwashing techniques when removing gloves and failed to remove gloves between dirty and clean tasks for 1 of 2 Nursing Assistants (NA #1) observed providing personal care to residents. Findings included: The facility policy, titled Handwashing, with a revision date of 10/2014, indicated handwashing was the single most important means of preventing the spread of infection. The guidelines indicated appropriate hand washing was performed under conditions that included before and after handling items potentially contaminated with blood, body fluids, excretions or secretions and after removing gloves. Resident # 17 was readmitted on 2/28/14 with diagnoses that included hypertension and diabetes. The quarterly Minimum Data Set (MDS), dated 10/13/14, indicated Resident # 17 was cognitively intact and required extensive to total assistance for bathing, toilet use and personal hygiene. An observation was made of Nursing Assistant	F 441	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS Criteria #1 NA #1 was re-educated and retrained on the facility handwashing policy and techniques by the Staff Development Coordinator through 1 on 1 training. Proper return demonstration was provided by NA #1 to the Staff Development Coordinator. 10/23/14 Criteria #2 All residents have the potential to be affected by this alleged deficient practice, therefore, all Nursing staff were re-educated by the Staff Development Coordinator on the facility Handwashing Policy and the guidelines and proper techniques of handwashing to include:	

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F 441	Continued From page 14 (NA) # 1 providing morning care to Resident # 17 on 10/22/14 at 10:14 AM. The NA donned gloves, removed the resident's clothing and turned her on her right side. When the resident was turned to her right side, it was apparent she had a bowel movement. The NA cleaned the resident and then removed one pair of gloves, leaving a pair of gloves on her hands. With the second set of gloves, the NA continued providing care. The NA stated she had not been told she could not double glove. She made no attempt to wash her hands after cleaning the bowel movement and before proceeding with washing the resident's lower extremities. Prior to cleaning the perineal area, NA # 1 emptied the water. She removed the gloves, but did not wash her hands prior to donning clean gloves. After completing the bath, the NA emptied the water and dried her hands. With the same gloves, NA # 1 placed a clean fabric pad underneath the resident, helped her dress and handed her the oxygen tubing. NA # 1 was interviewed on 12/22/14 at 10:42 AM. NA # 1 stated she had been taught to wash her hands each time gloves were changed and on completion of care and prior to exiting a resident's room. The NA stated she did not wash hands between glove changes. The NA acknowledged she had touched the oxygen tubing and clean pad before removing her dirty gloves. She stated she was nervous. An interview was held with Nurse # 1 on 10/22/14 at 10:51 AM. She stated staff were taught to wash their hands before and after gloving and in between dirty and clean tasks. The Staff Development Coordinator (SDC) was interviewed on 10/22/14 at 11:47 AM. She stated	F 441	Handwashing is the single most important means of preventing the spread of infection, appropriate conditions in which wash hands, The use of gloves do not replace hand washing, hand washing following 5-7 alcohol based applications and handwashing must be done for all residents with diarrhea instead of alcohol based products. All staff that has not been in-serviced by the target date will be removed from the schedule until they have been re-educated. Criteria #3 All Nursing staff were re-educated on the facility policy and guidelines and techniques of handwashing by the Staff Development Coordinator on the facility Handwashing Policy and the guidelines and proper techniques of handwashing to include: Handwashing is the single most important means of preventing the spread of infection, appropriate conditions in which wash hands, The use of gloves do not replace hand washing, hand washing following 5-7 alcohol based applications and handwashing must be done for all residents with diarrhea instead of	

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F 441	Continued From page 15 handwashing was the first line of defense against infection. Staff were taught to wash hands for 15-20 seconds. Staff are also taught hands should be washed prior to entering a resident's room, before leaving the room, after contact with residents and when gloves are taken off. The SDC stated she was not aware staff were double gloving and staff were not taught to double glove. The danger of double gloving and removing only one pair after cleaning a bowel movement would be the spread of infection. The SDC added nursing assistants were taught to wash hands and change gloves between dirty and clean tasks; adding it would not be ok to handle a clean pad or oxygen tubing with the same gloves used during the bath.	F 441	alcohol based products. All staff that has not been in-serviced by the target date will be removed from the schedule until they have been re-educated. Random handwashing audits were conducted by Staff Development Coordinator on varying shifts and units to ensure that proper handwashing techniques were carried out by staff. 11/12/14 Criteria #4 Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and RN Supervisors or will continue a minimum of 3 random audits weekly of handwashing on varying shifts and units to ensure proper handwashing is being performed for all identified residents. A minimum of 3 audits will be conducted 1 x week x 4 weeks, a minimum of 3 audits every 2 weeks x 1 month and monthly x 2 months. The results will be kept in the Director of Nursing Office. The Director of Nursing will incorporate the POC into the facility□s monthly Quality Assurance and Assessment meeting. The Director of Nursing will report any findings of inappropriate handwashing and	

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F 441	Continued From page 16	F 441	the report of re-education to the identified employee to the Quality Assurance Committee for 3 months or as deemed necessary. 11/12/14	